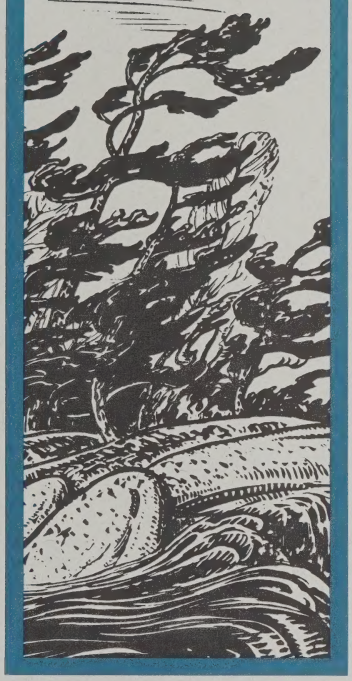

MANAGING HEALTH CARE RESOURCES

MEETING ONTARIO'S PRIORITIES

SUPPLEMENTARY PAPER
1992 ONTARIO BUDGET

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1992 ONTARIO BUDGET

MANAGING HEALTH CARE RESOURCES

MAY 1992

General enquiries regarding this supplementary paper to the *1992 Ontario Budget* should be directed to:

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The Cover: A.Y. Jackson, detail of Pine Island, from "Canadian Drawings - a portfolio of prints by members of the Group of Seven", 1925. Collection: Art Gallery of Ontario.

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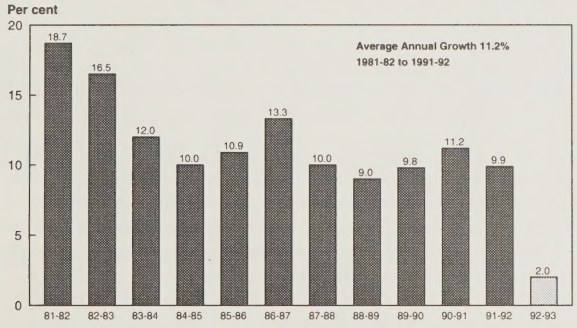
MANAGING HEALTH CARE RESOURCES

Introduction

Publicly funded, universal and accessible health care in Ontario, and across Canada, is much more than a government program or "public good" -- it is a fundamental and defining characteristic of Canadians. In Canada it is understood and strongly supported that the many who are well provide for the few who are ill.

However, medicare's future is at a crossroads. Throughout the 1980s, all provincial governments, including Ontario, devoted a tremendous amount of new resources to Canada's health care system. In 1980, the Ministry of Health's budget totalled $4.9 billion. By 1990, it had more than tripled, to $15.3 billion. This year, spending will reach $17.2 billion.

Annual Growth in Ministry of Health Spending
1981-82 to 1992-93

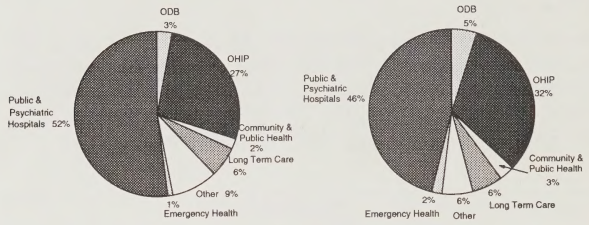


Entering the 1990s, in many ways Ontario experienced its worst recession since the Great Depression. Economic output fell, causing a decline in Ontario's revenues and a large increase in provincial expenditures. This, combined with the federal government's withdrawal of financial support for health, post-secondary education and social assistance, has led to large deficits for Ontario.

Clearly, Ontario cannot support continued double-digit growth in health expenditures. In fact, most agree we currently dedicate an appropriate amount of resources to health care, however, the relative allocation of

resources must be improved. The Government is moving to more prudently manage our health care resources to ensure our current system is maintained and actually enhanced.

Ministry of Health Expenditures
1981-82 to 1991-92



1981-82
$5.8 Billion

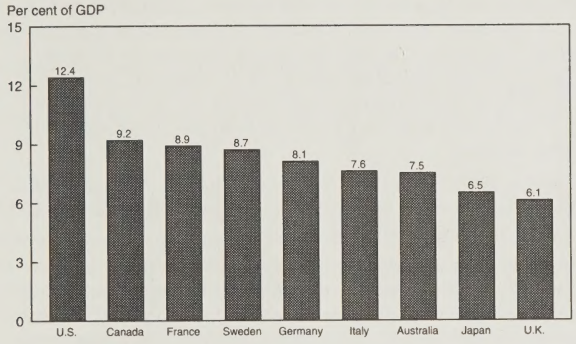
1991-92
$16.9 Billion

While our system requires improved management of resources, Canada's health care system is much more efficient and equitable than that of the United States. The United States dedicates 12.4 per cent of its Gross Domestic Product (GDP) to health care; the corresponding figure for Canada is 9.2 per cent. Despite devoting much more resources to health than Canada, some 37 million Americans have no access to health insurance and tens of millions are under-insured. In 1991, the United States General Accounting Office reported:

> *Canadians have few problems with access to primary care services. There are more physicians per person in Canada than in the United States, and Canadians use more physician services per person than do U.S. citizens. Yet the cost of physician services per person in Canada was one-third less than in the United States.*

While Canada's system is more efficient and equitable than the United States model, we dedicate more resources to health than any other country with a national health system. Countries such as Sweden and Japan, with a relatively older population, dedicated 8.7 per cent and 6.5 per cent of GDP respectively to health care and have higher measures of health status.

Total Health Expenditure as a Percentage of GDP (1990)



We know from the work of the Premier's Council on Health Strategy and the continuing work of the Premier's Council on Health, Well-Being and Social Justice that the traditional health care system is only one of many factors that contribute to the health and well-being of the population. Other determinants include our social and physical environments, employment, education, housing and social supports.

The Government has adopted five health goals first articulated by the Premier's Council:

Goal 1 Shift the emphasis to health promotion and disease prevention.

Goal 2 Foster strong supportive families and communities.

Goal 3 Ensure a safe, high-quality physical environment.

Goal 4 Increase the number of years of good health for the citizens of Ontario by reducing illness, disability and premature death.

Goal 5 Provide accessible, affordable, appropriate health services for all.

The Government is moving to create a better balance both within the health care system in terms of services and human resource management, and between the health care system and other determinants of health. For example, while health expenditures will moderate in 1992-93, the Ontario Budget announced significant new spending for non-profit housing, pay equity and a new JOBS ONTARIO training fund.

Most agree that a greater degree of efficiency can be achieved in our system while also enhancing its quality. The improved management of

health resources is an important component of the Ministry of Health's *Goals and Strategic Priorities:*

> *In Ontario, we have adopted a Vision of Health and Health Goals that reflect our commitment to preserving medicare and to developing healthy public policy. The Ministry of Health's strategic priorities for the next three to five years focus on finding ways to better manage the health care system, invest more in community-based programs, redress longstanding inequities in the system, and, most important of all, take a leadership role in preserving medicare.*

In the Supplementary Paper to the 1991 Ontario Budget, *Managing Health Care Funding,* the Government outlined several significant initiatives to manage health care resources more prudently:

> *The Government intends to implement measures which will provide more prudent management of the health care system in Ontario, while maintaining care standards. These measures will be implemented to allow the Government the flexibility to pursue investments in other determinants of health and to meet the future challenges of health care.*

These initiatives were introduced as initial measures in a continuous process of management improvement. Since the release of *Managing Health Care Funding,* the Government has made significant progress in the management of health resources in Ontario. The Government has embarked on several important management initiatives including:

- a restructuring of hospital funding;
- an important agreement with Ontario's physicians, to better control service growth;
- significant changes to the Ontario Health Insurance Plan's out-of-country payment policies;
- several cost-saving measures for the Ontario Drug Benefit Program; and
- key investments in the redirection of long-term care.

The Government is continuing to work with the hospital sector to moderate expenditures, increase efficiencies and improve quality of care. Further measures are being introduced to control the rapid increase in Ontario Drug Benefit Program expenditures and to ensure Ontarians receive the most appropriate drug therapy. Several initiatives will be introduced to the Ontario Health Insurance Plan to improve the quality and effectiveness of medical services. The Government will also work to ensure Ontario has an appropriate number, mix and distribution of physicians and other health practitioners to reflect the province's needs. New directions and priorities for our health care system will promote a higher level of health and well-being for all Ontarians.

The measures and restructuring now under way, and those to come, will result in the most significant change to our health care system since the introduction of medicare. The cooperative effort of all stakeholders is required if we are to maintain and enhance Ontario's health care system.

The following sections describe the measures undertaken since last spring and outline further measures being introduced by the Government to ensure health care resources are managed as prudently as possible and Ontario's health care system is improved.

Operation of Hospitals

In 1992-93, provincial transfer payments for the operation of hospitals in Ontario will reach $7.4 billion and represent 43 per cent of the Ministry of Health budget. Payments to hospitals account for almost 14 per cent of total provincial spending and are the single largest expenditure made by the Government of Ontario. Between 1981-82 and 1991-92, these payments grew at an average annual rate of 9.7 per cent.

Beginning in November 1991, the Ministry of Health undertook a review of hospital expenditures in consultation with major stakeholders in the sector, including the Ontario Hospital Association, the Ontario Council of Hospital Unions, the Ontario Nurses Association, the Service Employees International Union, the Ontario Public Service Employees Union, the Canadian Union of Public Employees, the Ontario Medical Association and the District Health Councils of Ontario.

The objective was to explore options for new and better ways of allocating resources to support hospital services, while moderating the growth rate in overall funding requirements.

In January, the Minister of Health released the *Program Review of Hospital Expenditures*, which outlined several areas where efficiencies in the system could be achieved. These include:

- better use of existing services;
- the shift from inpatient to outpatient care;
- better links between hospitals and community agencies;
- eliminating duplication of services; and
- better local and regional planning.

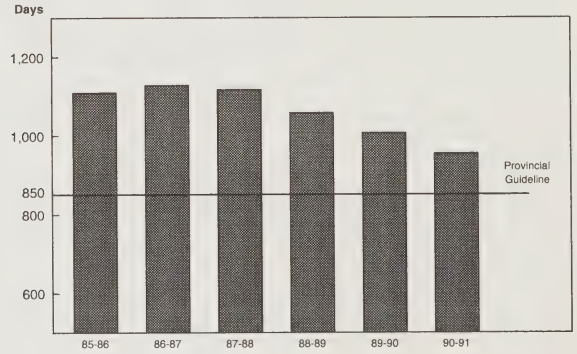
The Minister also announced a collaborative planning process to achieve these efficiencies and provide guidance for hospitals and communities in the restructuring of the hospital sector. The restructuring process is based on a comprehensive review of hospital and health care issues. It involves all stakeholders, including workers' representatives and district health councils, in determining local strategies to maintain services, control costs and preserve as many health care sector jobs as possible. To this end,

hospitals have been asked to conduct open budget and planning processes that make information available to all who are affected. The Minister established three major initiatives for improved planning, including:

- A joint Ministry of Health/Ontario Hospital Association policy and planning committee to plan and set standards for the provision of hospital services.
- A service restructuring committee to set standards and guidelines for service realignment. This will involve major stakeholders including hospital management, care providers and unions.
- Local/regional planning processes to coordinate the local restructuring initiatives. District Health Councils will have a stronger role in reviewing and coordinating service realignment in the hospital sector, within the context of an integrated health system.

The planning processes are being guided by the Ministry of Health's *Health Services Planning Framework*, released in January. For example, current and future planning for acute care beds will be based on a new guideline of 850 patient days per 1,000 population per year. The use of acute care beds has been decreasing over the past several years. In 1985-86, the average usage per 1,000 population was 1,110 patient days per year. By 1990-91, this number had declined by 14 per cent to 955. The new planning framework will assist in improving the efficiency and appropriateness of hospital services and will facilitate the Government's intention to move to more community-based care, as well as outpatient and ambulatory care.

Acute Care Patient Days per 1,000 Population

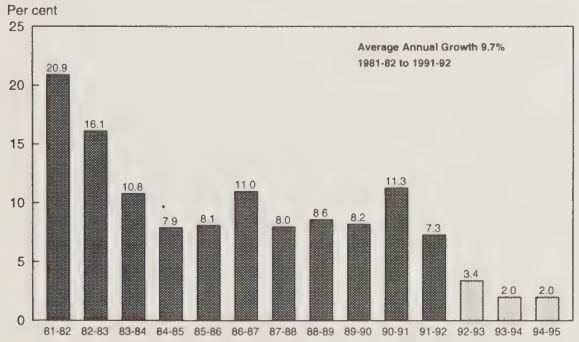


As well, in consultation with hospital unions, District Health Councils, the Ontario Hospital Association and the Ontario Medical Association, guidelines are being developed to ensure that hospital services, budget and human resources planning are comprehensive and open to all stakeholders and participants.

In January, the Treasurer announced a one per cent increase in general hospital funding. Further, the Minister of Health has announced $95 million in new targeted resources to maintain essential priorities and help accelerate restructuring of the hospital system. Of this, $49 million is to meet the need for such essential services as dialysis, bone marrow transplants, chemotherapy and cardiac surgery. The remaining $46 million is to accelerate the shift from institutional-based services to outpatient and community care, to support areas of high population growth and to reduce the historical funding inequities faced by some hospitals that have been cost-efficient.

In addition, the Minister announced that $30 million from cost-saving measures in the Ministry would be redirected to establish a Labour Adjustment Fund to minimize the impact for hospital workers affected by the restructuring. It is essential that necessary service realignments that displace hospital workers be balanced with counselling, job search, retraining and other progressive human resource initiatives. The Hospitals Training Adjustment Panel will develop these measures with the support of the Labour Adjustment Fund.

Annual Growth in Operation of Hospitals
1981-82 to 1994-95



In 1992-93, the Government will provide an increase of $242 million over last year. The new investment represents an annual growth rate of 3.4 per cent. This is a marked decline from the previous decade's annual average of 9.7 per cent.

The moderated growth rate for hospitals reflects the Government's commitment to move toward more community-based care while ensuring that patients in hospital receive appropriate and high quality care. Most individuals and organizations involved in the hospital sector agree that improvements in quality can be achieved. As described in the report from the Steering Committee, Public Hospitals Act Review:

> *Quality is a primary concern of the hospital. It is important that the hospital's emphasis be on continually improving the quality of care and on incorporating this commitment into the culture of the organization. This requires a shift from focusing on after-the-fact inspections and audits to continuous quality improvement in all clinical support, managerial and governance functions.*

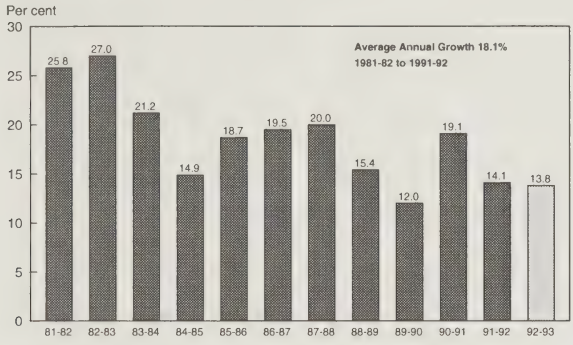
The Government is committed to working with all stakeholders to improve quality of care within the moderated expenditure increases.

Ontario Drug Benefit Program

The Ontario Drug Benefit Program (ODB) currently provides prescription and selected over-the-counter drugs free of charge to those aged 65 and over, home care recipients, residents of long-term care facilities and social assistance recipients. In total, the program provides comprehensive drug coverage for approximately 20 per cent of Ontario's population.

In 1992-93, the combined Ministry of Health and Ministry of Community and Social Services' ODB program is expected to cost $1.2 billion, an increase of 13.8 per cent over 1991-92. A significant portion of the growth in ODB spending over the past several years has been caused by the rapid increase in the number of social assistance recipients (who are eligible for ODB). For example, in 1992-93 the Ministry of Health's ODB program spending will increase by 10.8 per cent while the Ministry of Community and Social Services' ODB expenditures will grow by 26.0 per cent. Due to initiatives introduced last year and measures planned for 1992-93, the combined forecast growth rate of 13.8 per cent is much below the average annual 18.1 per cent experienced over the preceding ten years.

Annual Growth in ODB Program*
1981-82 to 1992-93



* Includes Ministry of Health and Ministry of Community and Social Services ODB Programs

Over the past decade, costs have been fuelled by increasing drug prices and dispensing fees, the introduction of new and often costly drugs, the growth in number of recipients, and an increase in claims per recipient.

The cost of an average ODB prescription has risen by 10.8 per cent per year. This has been caused by annual increases of 13.2 per cent in drug prices and a 6.6 per cent annual growth in the dispensing fee paid to pharmacists.

Utilization (growth in the number of prescriptions) increased by 6.9 per cent annually over the decade. The number of recipients grew by 5.0 per cent annually and the number of claims per recipient grew by 1.9 per cent.

The Pharmaceutical Inquiry of Ontario in 1990 and the Provincial Auditor's report in 1991 both identified the need to better manage ODB expenditure growth. Last year the Government announced several measures to improve the management of the program.

- The Ministry of Health announced in November that no new benefits would be added or price increases accommodated in 1991-92 for drug products already listed in the ODB Formulary (the published listing of all drugs covered and their prices).
- The Government also froze the ODB pharmacists' dispensing fee at $6.47 in 1991-92.
- An improved management system for oxygen therapy, which includes strict adherence to established medical criteria and pricing, has been implemented.

In 1992-93, the Ministry of Health will continue to implement significant changes to ODB.

- For 1992-93, the Ministry has established a guideline of two per cent for drug price increases. Products with a proposed increase over two per cent will be subject to review with the possibility of removal from the ODB Formulary.
- Prescribing and dispensing in larger quantities will be encouraged for well-stabilized ODB recipients on long-term courses of drug therapy. This will result in greater patient and prescriber convenience and reduce the number of dispensing fees paid by the Government.
- Changes in the coverage and price of over-the-counter drugs under ODB will be implemented.

The above measures reduced expenditures for the Ontario Drug Benefit Program by $57 million in 1991-92 and will save $112 million in 1992-93. In addition to these measures, the Government will initiate a major review of the ODB Formulary. This review will be based on an evaluation of therapeutic value and cost-effectiveness. It is expected that an additional $28 million in savings in 1992-93 and $59 million on a full-year basis will result from this review.

Drug Programs Reform Secretariat

The Government is moving to control the persistent double-digit growth in ODB expenditures. However, cost escalation is only one issue requiring reform. The Government is also planning to improve the equity of drug coverage in the province, reduce inappropriate drug use, improve stakeholder involvement and revise legislation to promote greater flexibility.

The Ministry of Health is implementing a major reform initiative for all public drug programs, including ODB and special drug programs for specific illnesses. The initiative is to be undertaken over the next two years, led by the newly created Drug Programs Reform Secretariat. The Secretariat will work toward a drug program that achieves six goals:

- Improvements in prescriber education to reduce inappropriate drug use.
- Cost containment of drug programs, with immediate and sustainable controls to keep the programs affordable.
- Empowerment of individuals to engage in meaningful discussions and decisions of their prescription drugs.
- Constructive partnerships with consumers, unions, professionals and the pharmaceutical industry in the planning, delivery and evaluation of public drug programs.

- Legislation changes that support reform and accommodate changing environments.
- Equitable protection against unaffordable prescription drug costs including pricing strategies and eligibility criteria.

Achievement of these goals will lead to public drug programs that improve the health status of Ontarians within the limited resources available to the Government.

Ontario Health Insurance Plan

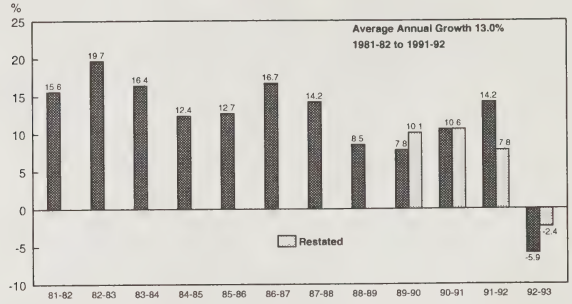
The Ontario Health Insurance Plan (OHIP) ensures access to a wide range of insured health care services for residents of the province. OHIP provides payments to physicians; other practitioners, for chiropractic, podiatry, osteopathic, optometric, dental and physiotherapy; and commercial laboratories. The plan also pays for Ontario residents receiving medical and hospital treatment in other provinces and countries.

In 1992-93, OHIP expenditures will total $5.0 billion, an actual decline of 5.9 per cent from 1991-92. This will be the first decrease in year-over-year spending since OHIP began in 1972. It will not result in reductions to medically necessary services. It will be achieved by several initiatives to manage expenditures and programs, to improve quality of care, and to reduce or eliminate unnecessary or over-utilized services.

In 1991, the Government entered into a comprehensive agreement with the Ontario Medical Association to provide better management of the previously "open-ended" fee-for-service arrangement with physicians. As well, the Ministry implemented changes to OHIP's out-of-country payment policy that resulted in a large decline in the use and cost of foreign services. The new out-of-country policy will save $210 million in 1992-93.

The Government will continue with new OHIP management measures to ensure that Ontarians receive the highest quality appropriate care. This will benefit those requiring care and will free resources for investing in the other determinants of health.

Annual Growth in OHIP Payments
1981-82 to 1992-93



Note: The restated figures distribute $189 million in payments made retroactively in 1991-92 for fiscal years 1989-90 and 1990-91. The restatement presents the actual retro fee award of $138 million made in 1991-92 in the years for which it was based ($66 million for 1989-90 and $72 million for 1990-91). Also the lump sum malpractice insurance assistance of $51 million made in 1991-92 has been distributed to the years for which they were retroactive ($2.3 million for 1989-90 and $28 million for 1990-91).

Government/OMA Agreement

Over the past year, the Government and the Ontario Medical Association (OMA) have worked together on the implementation of a comprehensive agreement signed in May 1991. A cornerstone of this agreement was the creation of the Joint Management Committee (JMC), a senior liaison and management mechanism between the Government and the OMA. The JMC's mandate is to evaluate existing benefits and improve the overall management of physician and related health services.

To support the work of the JMC, the Minister of Health recently announced the establishment of the Institute for Clinical Evaluative Sciences (ICES). The Institute will conduct research to assist the JMC in fulfilling its role to improve the quality and effectiveness of medical services in Ontario. This will include examining the appropriateness and regional variation in procedure patterns.

The agreement with the OMA also established thresholds of $400,000 and $450,000 for individual physician billings. Eligible payments above these ceilings are reduced by 33 per cent and 67 per cent respectively. Some 870 physicians (about 5 per cent) have been affected by these thresholds, resulting in $33 million in savings in 1991-92.

To ensure that these limits do not adversely affect regions in Ontario where specialists are in short supply, the Government has developed a Specialist Retention Initiative to extend the Underserviced Area Program.

Another component of the agreement with the OMA was the establishment of overall utilization controls. For 1991-92, the total growth in the number of services was approximately six per cent. Under the new sharing formula, the Government will pay the first 1.5 per cent above population and demographic adjustments, and share the remainder equally with the OMA. Implementation of the overall utilization controls will result in savings of $100 million in 1992-93 ($50 million of which relates to the 1991-92 fiscal year).

Last year, the Government awarded a one-time payment of $138 million in lieu of fee increases in fiscal years 1989-90 and 1990-91. In previous agreements, retroactive awards were added to future annual payments. Since this is a one-time payment, it represents annual savings of $138 million for 1992-93 and beyond.

In total, the Government/OMA agreement has generated $33 million in savings in 1991-92 and will save an estimated $271 million in 1992-93. More important, the agreement provides a framework for a new cooperative relationship that improves the quality and effectiveness of medical services in Ontario.

OHIP Schedule of Benefits

The Ministry and the OMA are also working together through the JMC to examine the current OHIP schedule of benefits to ensure that benefits are medically necessary and cost effective. For example, in November, the Ministry of Health "delisted" epilation (hair removal) as an insured benefit. This resulted in savings of $4 million in 1991-92, and is estimated to save $10 million this fiscal year.

The review will include the use of alternative qualified health professionals to provide such services as dialysis, audiology testing and physiotherapy. The medical benefit of procedures and services insured in Ontario but not in other jurisdictions will also be reviewed. The Government and the OMA will examine OHIP's payment mechanism to ensure that incentives are in place to promote the most appropriate care for Ontarians. For example, incentives that have caused a proliferation of walk-in clinics will be examined. This review is expected to save $80 million in 1992-93.

Out-Of-Country Payments

Prior to late 1991, OHIP provided almost complete coverage of the amount billed by foreign health institutions for residents travelling outside Ontario. Payments for these out-of-country services increased dramatically from $100 million in 1988-89 to $281 million in 1991-92. This growth was fuelled by a rapid increase in the cost of health care in the United States and an aggressive marketing strategy to "import" Ontario patients.

In the Supplementary Budget Paper, *Managing Health Care Funding*, the Government announced its intention to control this rapid growth in expenditures. In October 1991, the Minister of Health announced these changes to OHIP's out-of-country payment policy:

- The Province will pay for unexpected hospital care received outside of Canada at rates similar to those paid in Ontario.
- Residents in need of treatment not available in Ontario can request prior approval to be paid in full for care elsewhere. To date, some 60 per cent of applications for out-of-country health services have been denied and referred, where appropriate, to available Ontario or Canadian treatment centres.
- Ontario patients who leave Canada for the sole purpose of receiving hospital services, without prior approval, are reimbursed a maximum of $400 per day. Previously, such treatment was paid at 75 per cent of the amount billed.
- The Ministry of Health has successfully negotiated lower rates from U.S. hospitals for claims predating the new policy. Most have settled for 50 to 60 per cent of the amounts originally billed.
- Through a tendering process, the Ministry will receive preferred, discounted rates from some U.S. health facilities when treatment is unavailable in Ontario.

Together, these initiatives saved $80 million in 1991-92 and will save $210 million in 1992-93. Some further changes will be necessary to ensure the full implementation of the out-of-country payment policy.

The Ministry continues to improve Ontario health services to reduce the need to travel to the United States to receive such specialized treatment as cardiac care, acquired brain-injury services, and alcohol and drug addiction treatments. Recent initiatives include the following:

- Ontario's cardiovascular care capacity has increased by 31 per cent since 1989. Registries were established in 1990 to identify available heart surgery capacity for adult and paediatric cardiac care. The registries are being expanded to include free-standing catheterization laboratories in Windsor, Sault Ste. Marie, Thunder Bay and Scarborough.

- In 1992-93, $9 million in new resources will be devoted to acquired brain-injury treatment and community care.
- Addiction services have been enhanced, including community support programs and residential services. In 1992-93, the Ministry will provide an additional $6 million to support these services.

The Government introduced these changes to control the rapid increase in foreign payments and, more important, to redirect resources to ensure that fewer Ontario residents have to travel out-of-province to receive health services.

Commercial Laboratories

In 1991-92, commercial laboratory services represented the second largest component of OHIP at $490 million. Expenditures for private labs have been growing by more than 12 per cent per year, with an 11 per cent increase in the volume of tests. This is almost double the growth in the volume of physician services.

Following consultations with the Ontario Association of Medical Laboratories, the amount paid for 18 specific tests was reduced or modified effective January 1, 1992. These changes are expected to generate $25 million in savings annually.

The Ministry is enacting a new payment policy for commercial laboratories, including a review of the appropriateness of some services.

- The existing discount factors for large volumes of tests will be increased. The new discount factors will also be expanded to include tests ordered by specialists.
- The Ministry is reviewing the growth in laboratory testing and will implement a new utilization sharing formula effective April 1, 1993. This formula will reduce payments to commercial laboratories by 50 per cent when the number of tests grows more than two per cent per year.

It is anticipated these measures will save $11 million in 1992-93. The Ministry will also launch a major laboratories' review this year to better manage payments to commercial laboratories. All stakeholders will be consulted to develop a more efficient and integrated approach to the provision of services. The review will examine all tests and payment mechanisms currently in place, examine physician ordering practices, and will promote the use of public health and hospital laboratories.

Other Practitioners

In 1991-92, OHIP payments included $220 million to "other practitioners" for chiropractic, podiatry, osteopathic, optometric, dental and physiotherapy services. Payments for these services have increased by more than 40 per cent over the past five years.

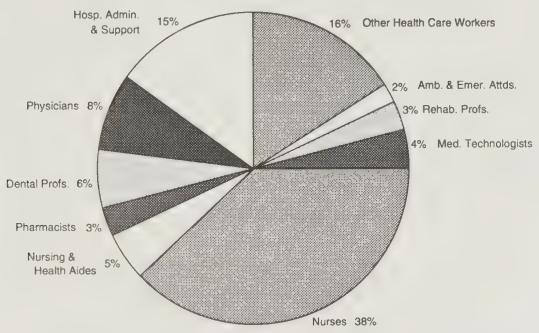
The Government will enact the following measures to better manage growth in other practitioner payments:

- The existing payment policy for chiropractic, podiatry and osteopathic services will be frozen until a review on future directions for these services in the community is undertaken.
- A new utilization formula for optometrists will share 50/50 any growth over a set percentage above a demographic allowance.
- A new per capita allocation system for physiotherapy services will be developed to promote equitable availability of services.

These measures are expected to save $5 million in 1992-93. The Ministry of Health will implement these measures in consultation with the stakeholders involved.

Managing Health Human Resources

The vast majority of health care expenditures are not consumed by building new hospitals and purchasing new technologies. Our health care system is dominated by people -- there are approximately 279,000 workers involved in the health care sector in Ontario. Payments to providers of care, such as physicians, nurses, and rehabilitation workers, comprise 75 to 80 per cent of provincial health spending. This will represent about $13 billion in 1992-93.



Despite this, there has never been a concerted effort to effectively manage and plan health human resources in Canada. Historically, projected requirements for individual professions have been based on past patterns of use, rather than on the present or future health care needs of the population. This approach tends to perpetuate inefficiencies and limits the introduction of improvements.

In *Achieving the Vision: Health Human Resources*, the Premier's Council on Health Strategy stated:

> *Human resources are the single most powerful instrument available to realize [our] future vision of the health care system and, ultimately, the vision of health for Ontario.*

To achieve the best patient outcomes, future health human resource planning must encourage the delivery of quality service with maximum productivity. That means ensuring the availability of an efficient mix of health care providers appropriately distributed across the province in a variety of settings.

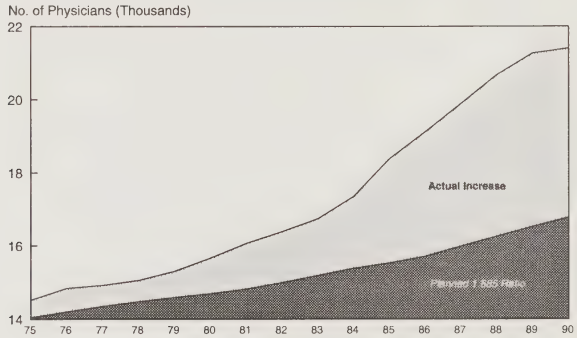
Physicians are a particularly important part of health human resource planning. Traditionally, physicians have acted as "gatekeepers" to a multitude of health care services. As such, they greatly influence the use of hospital services, drugs, chronic care facilities and the services of other health care providers. Their decisions have an enormous impact on access to care, quality of care and costs to the taxpayer.

In approaching the task of reviewing the management of health human resources, the Government is beginning with a discussion of physician human resources.

Physician Human Resources

In 1975, the Government endorsed a target physician-to-population ratio of 1:585, although few effective mechanisms were put into place to achieve this goal. By 1990, Ontario had an excess of 4,627 physicians over this Provincial goal. In fact, since 1981, the number of physicians in Ontario has grown almost three times faster than the population.

Physician Increase in Ontario
Actual vs. Planned 1:585 Ratio



Ontario's 1991 agreement with the OMA established a payment envelope for all physicians billing fee-for-service. The size of the envelope and its rate of growth are specified in the agreement, but the number of physicians is not. In addition, there are few limits on physicians' type of work or location of practice. This lack of planning and management has resulted in shortages of specialists in some areas of the province, while other areas have an oversupply. For example, there are almost twice as many obstetricians per 100,000 population in eastern Ontario than in the north.

Similarly, the types of specialists are not necessarily influenced by the actual needs of the population. For example, there was a 46 per cent increase in the number of paediatricians between 1981 and 1989 but only a four per cent increase in their patient population.

There are significant differences in physicians' practice patterns, as is shown by large variations in the incidence of some procedures. A baby born in northwestern Ontario, for example, is 43 per cent more likely to be delivered by caesarean section than a baby born in the southwest.

A number of factors affecting the number, distribution and mix of physicians have not been managed effectively by the Province. Examples include:

Training - Content and location of medical training can influence specialty choice, practice setting and practice location. Currently, most training occurs in teaching hospitals in southern urban centres, which has led to a predominance of specialists and subspecialists in these areas.

Entry into the province - Between 1981 and 1990, Ontario licensed an average of 597 physicians per year from Ontario medical schools and an average of 467 physicians per year from non-Ontario medical schools. Of the total number of non-Ontario physicians newly licensed in the last ten years, about half received their medical degrees from other provinces and the remainder from outside Canada.

Ontario has 200 to 400 more residency positions than it needs to train its own medical school graduates, which provides a major source of this migration. Reducing the capacity of the postgraduate training system would moderate the flow of physicians into the province. Alternatively, trainees from outside the province could be encouraged to return home after completing residency training.

Licensing - The practice of medicine is regulated by the College of Physicians and Surgeons of Ontario. Currently, every qualified physician receives a licence regardless of the needs of the population, and there are few incentives for physicians to retire.

Payment - The method of payment influences practice behaviour by providing incentives. For example, fee-for-service remuneration encourages large volumes of service. The vast majority of physicians are paid on a fee-for-service basis by OHIP. Any licensed physician is eligible for a billing number and compensation.

Level of income affects the number, mix and distribution of practising physicians. Ontario may attract physicians from other provinces, based on higher average incomes, just as trainees may choose the more lucrative specialities. Similarly, areas with low patient volumes may not attract physicians, due to the reduced potential for remuneration.

A better distribution of physicians could be achieved by introducing differential fee schedules, which pay more per procedure in underserviced areas and less in oversupplied areas. Better distribution could also be achieved by identifying the number of physicians needed in a region and issuing only the required number of billing numbers.

A National Approach

The issue of physician resource management is important not only for Ontario but for every province. All Ministers of Health in Canada see this issue as key to strengthening the health care system and preserving the principles of the *Canada Health Act*.

In January 1992, the Provincial/Territorial Conference of Ministers of Health held in Banff adopted a series of strategic directions for physician human resource management. At this meeting, representatives from six national medical organizations provided a consensus statement that recognized the need for a nationally coordinated physician resource strategy.

The strategic directions adopted by the Provincial/Territorial Conference of Ministers of Health included:

- reducing the number of doctors trained by Canadian medical schools;
- establishing national clinical guidelines;
- making medical care expenditures more predictable;
- replacing fee-for-service with other methods of payment;
- increasing the use of alternative service delivery models;
- restructuring academic medical centres to meet the health care needs of the population;
- improving access to clinical services in rural communities;
- ensuring continuing competency of physicians; and
- promoting flexibility between professional groups.

The Ontario Strategy for Physician Human Resource Planning

The Ontario Ministry of Health recognizes the need to develop a physician human resources strategy that complements national directions. As an initial step, the Ontario and federal governments will co-host a national conference on physician issues in Ottawa in June. The conference will provide a discussion forum for federal, provincial and territorial governments, and various stakeholder groups.

In consultation with stakeholders, the Government will also develop a comprehensive physician management strategy to better manage the number, mix and distribution of physicians in Ontario. This strategy will be linked to a national plan and based on the documented health and cultural/linguistic needs of the population. The Government will work toward:

- better aligning the educational supply of physicians to the health care needs of the province;

- modifying the medical education experience to better prepare physicians for the settings in which they will eventually practise;
- exploring ways to better distribute physician human resources geographically and by health care setting; and
- creating a system of linked, regional, multi-disciplinary referral networks to effect a mix and distribution of physicians that provides a more rational means of accessing health care providers.

It is anticipated that $80 million in 1992-93 can be saved through improved physician human resources planning. This strategy will be implemented in consultation with the Ontario Medical Association, the College of Physicians and Surgeons, the Professional Association of Interns and Residents of Ontario, medical schools and other stakeholders. The goal of this reform is to provide an appropriate number, mix and distribution of physicians to reflect the needs of Ontarians.

Other Health Human Resources

The physician human resources strategy outlined above represents the first step in a continuing process to ensure that Ontarians receive the most appropriate medical care and that services are based on the needs of the population.

The Government will continue to examine the issue of health human resource planning for other professions and providers. Ontario has made some progress–the *Regulated Health Professions Act* will make the professional regulatory system more flexible. It also provides a greater opportunity for professions to expand the range of services they provide to the public.

Under current legislation, members of certain professions have an exclusive licence or monopoly over the provision of services that fall within the scope of practice of their profession. This system creates unequal relationships and inhibits cooperation between groups of practitioners. Under the new system, every profession has a described scope of practice; the controlled acts then list which activities are restricted to members of the various professions.

The Act includes a scope of practice statement for all 24 health professions to be regulated. For example, the expanded role of nurses reflects the fact that in many circumstances nurses provide care based on their own judgment and not on the order of a physician. Therefore, nurses will be able to perform designated procedures on their own authority. The *Nursing Act* regulations, which are being designed now, will designate these procedures and will specify which nurses may perform them and under what conditions. Under these new conditions, nurses will have expanded roles that will create opportunities for improved service delivery.

Improved Management of Health Resources

The Government is committed to improving the management of health resources. As announced in the 1992 Ontario Budget:

> *Ontarians are fiercely proud of our universal and accessible public health care system. But maintaining the quality of Ontario's health care system while reducing rapid expenditure growth is essential to preserving medicare. Total health care costs have increased at an annual rate of 11.2 per cent over the past ten years. This high level of growth is simply not sustainable.*

The paper has outlined specific initiatives the Government is implementing to accomplish this commitment. These initiatives continue the initial strategy outlined in last year's supplement to the 1991 Ontario Budget, *Managing Health Care Funding*.

The following tables outline the savings resulting from last year's announcements and the new initiatives detailed in this paper. Total savings from new measures introduced in this document will equal $204 million in 1992-93. The initiatives now under way and the new measures being introduced in 1992-93 will result in $832 million in savings this year.

These savings estimates include specific management initiatives being introduced by the Government and do not reflect the general moderation of health spending. For example, the 1992-93 spending growth for hospitals is 3.4 per cent. Since each percentage point of hospital funding is valued at $74 million, this moderation represents a large savings compared to historical growth rates.

The introduction of all these measures will help ensure the future viability of medicare as we move to a more efficient and equitable health care system to promote the health and well-being of all Ontarians.

Savings From 1991-92 Initiatives **Table 1**

($ Millions)

	1991-92	1992-93
OHIP		
Physicians' Agreement		
- Individual Thresholds	33	33
- Overall Utilization Controls	–	100*
- One-time Payments	–	138
Out-of-Country	80	210
Review of Benefits	4	10
Commercial Labs	2	25
Subtotal	119	516
Ontario Drug Benefit	57	112
Total	**176**	**628**

* $50 million is in respect of fiscal year 1991-92.

Savings From 1992-93 Initiatives **Table 2**

($ Millions)

	1992-93
OHIP	
Physicians Human Resources	80
Review of Benefits	80
Commercial Labs	11
Other Practitioners	5
Subtotal	176
Ontario Drug Benefit	28
Total	**204***

Total 1991-92 and 1992-93 Initiatives	**176**	**832**

* The 1992 Ontario Budget identifies $246 million in health savings. This figure includes the $50 million in savings from the physicians' agreement in respect of 1991-92 but realized in 1992-93. Also, the budget number only reflects health savings. $8 million of the forecast $28 million savings in ODB is from the Ministry of Community and Social Services program.

Future Directions in Health Care for Ontario

The preceding pages outline how the Government intends to more prudently manage Ontario's health care resources. This management is crucial if we are to maintain our publicly funded universal health system and implement changes to improve the health status of Ontarians.

The reforms being implemented are the most significant since the introduction of medicare. The Ministry has adopted new standards of practice to guide this reform program:

- Improve system management to ensure effective use of scarce resources.
- Ensure that all planning and service delivery in Ministry programs is done on the basis of reliable, needs-based, population health data and analysis.
- Attain the highest quality of service.
- Ensure that at every level, through consumer and worker involvement, appropriate accountability mechanisms are built into every Ministry program.

Ministry Priorities

The Ministry of Health is moving forward with several significant measures to improve program delivery and the equity of Ontario's health care system. These measures were announced in the Ministry's *Goals and Strategic Priorities*. Beyond the initiatives previously outlined, the Ministry will also be undertaking the following priorities.

Delivery System Reform

Moving toward a systematic approach to delivery of services includes developing programs to encompass the whole spectrum between prevention and treatment. This Ministry is implementing the following priorities:

Long Term Care Reform

Increase overall resources by $647 million over the next five years to move from reliance on institutions to a strengthening of community services to support individual choice.

Mental Health Reform

Develop a comprehensive framework to meet individual mental health needs, including reforming services to be sensitive to gender, culture and race. The reform will emphasize the integration of community-based care and institutions, community support and the involvement of consumers and their families.

Cancer Strategy

Develop a comprehensive provincial strategy that emphasizes prevention, early detection, diagnostic and treatment services, community support and education.

Tobacco Strategy

Enact new legislation and take other measures including committing $8.3 million in new resources to reduce the incidence of tobacco-related deaths, now 13,000 per year in Ontario. Tobacco use is the leading preventable cause of premature death.

Community Health Strategy

Develop a comprehensive community health and public health strategy for the delivery and funding of primary care. It will include increased emphasis on community-based primary care, especially for services that promote and maintain health and prevent disease and disability.

Diabetes Strategy

Establish Regional Diabetes Care Networks to provide improved care for residents in northern Ontario where there is a shortage of diabetes services. The northern strategy will serve as a working model to provide diabetes services across the province.

Equity Reform

Improvements will be made to redress inequities in access and services so that historically disadvantaged groups have the same opportunities for improved health status as all Ontarians. Areas of priority are:

Aboriginal Health

The Ministry will work with aboriginal communities to establish equitable, culturally sensitive health services to meet the needs of aboriginal people.

Women's Issues

The Ministry and stakeholders will develop a provincial women's health strategy to ensure that women have access to effective and appropriate care. A reproductive health strategy will include abortion services, the implementation of the midwifery profession, prevention of infertility and the development of quality assurance programs for caesarean births.

Children's Health

The Ministry will work to improve prenatal care, and reduce premature birth and diabetes. This is part of the Government's priority to improve the health and well-being of children in Ontario.

AIDS

The Ministry will work to prevent the spread of HIV, address the needs of persons living with HIV/AIDS and promote a humane, compassionate and knowledgeable societal response to this epidemic. A new advisory committee on HIV/AIDS has been established to increase the involvement of people living with HIV disease, representatives of community-based groups and health professionals experienced in treating HIV and AIDS.

Rehabilitation Services

Technology advances allow more people to survive severe trauma and allows many to return to community living. Demands for rehabilitation services are growing both for trauma patients and the elderly. The Ministry will develop a systematic approach to the planning, development and coordination of rehabilitation services.

Economic Renewal

Ontario's health care industries contribute to economic renewal. The Government is pursuing strategies to promote health care industries by attracting major new investments by health care firms.

The Government is committed to continuing its efforts to make our health system as effective and efficient as possible while assuring the best quality of service. These efforts are critical if we are to maintain medicare and meet the future challenges of health care.

Federal Support for Health Care in Canada

Canada's national health system is actually 12 separate systems administered by provinces and territories, joined by national standards and financed by federal, provincial and territorial governments.

The federal government provides support for health care and post-secondary education through Established Programs Financing (EPF). The federal government has unilaterally introduced six changes to EPF that have greatly reduced the federal government's role in supporting health care in Canada. For example, the federal share of expenditures for health and post-secondary education in Ontario has fallen from a high of 52 per cent in 1979-80 to its present rate of 31 per cent. In dollar terms, the federal measures have resulted in a cumulative loss of $12.3 billion for Ontario. Nationally, these cumulative losses equal $33.6 billion.

In order to maintain or enhance Canada's health care system, provinces have been forced to replace the vacated federal support. This shift has placed Canada's much-envied health system in jeopardy. As outlined in the 1992 Ontario Budget:

> *...the national standards embodied in the provincial programs that are supported by federal transfers are increasingly under threat. The deterioration in the fiscal arrangements supporting health care, for example, has resulted in a situation where Canada's health care standards are under more pressure today than at any time since their adoption.*

In order to preserve medicare in Ontario, the Government is introducing significant measures to improve the management of health care resources. However, Ontario believes that federal action is urgently required to restore national funding to ensure Canada's system does not degenerate into a series of very different provincial and territorial systems, providing Canadians with varying levels of care based on residency, not health need.

In the 1992 Budget, Ontario called for a reform of the federal transfer system, including EPF:

> *Federal measures to restrict their EPF costs threaten to undermine Canada's universal health care system. A renewed federal commitment to EPF's original terms is urgently required. This would entail a restoration of federal support to more appropriate levels and a growth over time of that support at rates in line with the growth in the economy.*

To maintain and enhance Canada's health care system will require the active and cooperative participation of the federal and provincial governments, all stakeholders and all Canadians. We must succeed at protecting our system and at the same time introduce improvements that lead to increased health and well-being for all. The alternative is simply not acceptable.

Conclusion

The measures outlined in this document represent the most widespread and significant reforms to Ontario's health care system since the introduction of medicare. These initiatives are being introduced to better manage Ontario's health care resources in order to preserve medicare and to provide the flexibility to enhance our health system.

The Government is implementing new management initiatives for the Ontario Health Insurance Plan and Ontario Drug Benefit Program and is restructuring Ontario's hospital system. A new health human resource planning strategy will be established to promote an appropriate number, mix and distribution of physicians and other professionals based on the health needs of the province.

The Government is also moving to implement several key goals and strategic priorities to improve program delivery and to enhance the quality and equity of Ontario's health care system. The Government will work towards creating a better balance both within the health care system in terms of services and human resource management and between the health care system and other determinants of health.

Improvements in the management of Ontario's health care resources is crucial if we are to maintain our system and implement changes to enhance the health and well-being of all Ontarians. The Government will continue to work with all health stakeholders to enhance quality and to ensure that Ontario's future health system is the most efficient and equitable possible.